Responses to Proposed Amended Rule

Administrative Code Chapter 580-5-33 Administrative and Support Requirements for Community Providers of Intellectual Disabilities Services

580-5-33-.02(6) – Supported Employment Definition: The comment was that all persons cannot work and receive minimum wage and that the Department of Labor allows for subminimum wage payment.

Response: This definition was updated to be consistent with CMS Core Definitions that are billable through the HCBS waiver programs. CMS has indicated that payment for sheltered work can no longer be billed through the waiver. Beginning October 1, 2017, billing for sheltered work under Prevocational Services or any other waiver service will not be allowed.

580-5-33-.02(17) – Community Specialist Service: Question about how the Community Specialist will be employable.

Response: It is acknowledged that all case managers may not be immediately equipped to adequately handle the DMH-DD authorized Personal Outcome Measure/Person Centered Planning (POM/PCP) process facilitation, even with training. Ways to fund and promote experienced plan development are being considered. The Community Specialist is a waiver service which requires employment/supervision from an entity who is not a provider of waiver services, aka- conflict free. The service description of this is similar to a case manager but not commensurate. It is a short term service and is not intended to replicate the services of a case manager who is performing targeted case management services as defined in the Alabama Medicaid State Plan. The use of this service for Case Management agencies which are conflict free is one of the avenues being considered to build expertise, provide a career ladder opportunity and to access additional funding while reducing/shifting the duties of the case manager. Again, at this point, the use of the Community Specialist is only one of the avenues being investigated.

580-5-33-.04(7)(a) – Exercise freedom of movement: The question was regarding keys and whether this applied to one's home only or also the medication cabinet.

Response: The need for people to be assessed for use of keys was a requirement of the new CMS rules. Not having a key was a trend identified in the Site Analysis Self-Assessment in October of 2014. The use of keys was specific to the person's home. People should be assessed annually regarding their ability to manage their own medication. If the team determines that the person can do this, arrangements should be made for the person to have access in a safe and secure manner.

580-5-33-.05 – Dignity and Respect: There was a recommendation to add language regarding consent and use of monitoring equipment.

Response: The following language is recommended. The organization has policies related to privacy that address consent and use of video surveillance equipment and other electronic recording devices such as cell phones, cameras, video recorders, etc.

580-5-33-10(11) – Executive Director Qualifications – The comment was that current directors could lose their jobs.

Response: Current directors not meeting the qualifications will be "grandfathered in". A statement to that effect will be added to the Administrative Code. Once codified, new applicants will be required to meet the required qualifications.

580-5-33-10(13) – QDDP Definition – Two respondents asked if it would be the QDDP or the case manager who would facilitate the PCP meeting. Also, there was a question regarding training to meet the new QDDP requirements.

Response: The "Meaningful Day" pilots have already been conducted. As the authorized POM/PCP process is gradually rolled out, the preparatory training details the responsibility of the case manager to ensure the POM/PCP process used is consistent with the ADMH-DD Division authorized process. The expectation is that the person employed by the Case Management agency, has passed successfully the new QDDP process, POM and PCP trainings. The nature of the training experiences will inherently dictate the pace of training.

POM trainings are offered at least quarterly in each region. If a provider or Case Management agency has sufficient numbers of staff needing training, a class can be scheduled for the specific organization. Staff hired to be QDDP's can function as a QDDP during the training period if a certified QDDP signs off on their work. Once the regulations are codified, those staff currently serving as a QDDP will have one year to receive necessary training. The requirement for the Q to co-facilitate a PCP meeting will be deleted. Organizations can request PCP Training assistance if needed. Case management supervisors and Community Specialists can participate in a train the trainer process in order to provide supervision and training to new facilitators.

580-5-33-11– Positive Services and Supports – The comment was that this section excludes case management… if they are to write the plan, then this makes no sense….

Response: This section details the nature of the services and supports designed by the person's Team. Several sections describe the expectations of the planning process which would apply to any provider of service/supports who is a member of the person's team. It is NOT the case manager who writes the PCP, rather it is the job of the Team to design the PCP content based on the person's interests and choices and dreams. Except for the portions which are specific to the case manager's unilateral responsibilities, such as quarterly narrative creation, etc. the case manager is the recorder of the PCP content as determined by the Team. It is every Team member's responsibility to render positive services and supports if they provide services or supports.

580-5-33-.15 (2) a. – Case management standards: The comment was that "follow-up needs to be defined with specific areas… an example is that providers and DMH do not share findings of any incident investigations with the case manager."

Response: This section of the code did not change. The definition of the core element of case management known as follow-up is defined in the Alabama Medicaid Provider Manual Chapter 106 and has not changed. It is not a reasonable expectation to define the expected follow-up actions for every specific situation, especially since the follow-up would be individualized for the situation and, in particular, for the person. As to the example of the lack of sharing of the findings of the investigation with the case manager, the current incident prevention and management system requires the notification of the Case Management agency of the occurrence of a reportable incident, the type of incident reported and only the result of the investigation as to substantiation or non-substantiation should the incident be an allegation of abuse, etc. As always, when a reportable incident is found to have occurred but not reported to the case manager, notification of the regional office person assigned to handle reportable incidents should be notified.

580-5-33-.15 (3) b. – The comment about whether the case manager is expected to write the PCP – this has been previously answered. The comment was about whether the requirement to write the PCP has

been approved by the "State Medicaid office as this is a requirement in their Optional Targeted Case Management funded service."

Response: Alabama Medicaid has specified Case Planning as one of the six core elements of Targeted Case Management for case managers. The Centers for Medicare and Medicaid services have specified that it is the expectation of the facilitator of the Person Centered Planning process NOT to be a provider of service to the person. Alabama Medicaid has tentatively approved the current components of the Case Management Plan to be added to the singular plan generated from the authorized POM/PCP process. This is why the Case Management Plan wording has been struck. It is the expectation that Alabama Medicaid will grant final approval for the discontinuance of the current Case Management Plan for those people for whom the authorized POM/PCP process has been used and includes the routine activities of the case manager currently included in the separate Case Management Plan. This final approval is expected at the close of the 2nd phase of the "Meaningful Day" pilot using the authorized POM/PCP process by the end of this fiscal year.

580-5-33-.15 (3) c.1 – Comment asked about visits, re-assessments and follow-up expected duties that require travel, funding for which has been threatened to be eliminated.

Response: Medicaid has approved a rate increase to address adequate costs of case management services. This increase was provided with input from Case Management agencies. Medicaid has also promised to provide statewide training when these billing changes go into effect.

580-5-33-.15 (3) e. 4- Team Minutes – The minutes of the team meeting is the plan. This will be deleted.

580-5-33-.15 (3) e.(6) (ii) – Comment notes that the functional assessment is done by the QDDP and the ICAP is done by the case manager

Response: This requirement is not new. ADMH regulations in Factor 13 at indicator B. specifically requires that a functional assessment is completed by the case manager. As forthcoming Standard Operational Procedures for case management are developed this fiscal year, the issue of a functional assessment completed by the case manager will be clarified.

580-5-33-.15 (3) e. (6) (iii) – Requires 90 day review of Plan of Care and PCP. The comment noted a confusion with the Case Management Plan and the quarterly vs. 90 day review.

Response: Since the endorsed POM/PCP document will eventually substitute for the Case Management Plan, the 90 day review will shift to the PCP document. The requirement is a maximum 90 day review (can be done more frequently), rather than quarterly review as is allowable for the narrative.

580-5-33-.15 (3) f – Monitoring – The comment is that there is not a specification of how information is received from the provider and the type of information received. An additional comment made about the future capacity of billing for travel (previously addressed).

Response: This requirement is not new. Monitoring is one of the six core elements and is defined by Alabama Medicaid in Chapter 106 of the Alabama Provider Manual. Monitoring is at minimum inclusive of all the services listed on the Plan of Care. The current case management standard operational procedure for the narrative includes a DMH approved process to secure written documentation from the provider of the service and what the documentation should show, including the units provided. How the information is transmitted and in what format is not regulated.

580-5-33-.15 (3) f (4) – Case management service termination process sharing w/ person – The comment was should the person terminate case management services, what will happen?

Response: This requirement is not new. When the person declines case management services, the Case Management agency offers to resolve the desire to change, such as a change to a different case manager within the agency. If the efforts of the Case Management agency are not effective, it is the responsibility of the Case Management agency to contact the appropriate DMH/DD Regional Office for further instructions to offer the person additional options from which to choose.

580-5-33-.15 (3) f (5) – Discharge/transfer plan format - Is there a format for these plans?

Response: Just as now, depending on the nature of the change, the format will be the same as it would be now for any non-redetermination special team meeting, reflective of the relevant changes, if any, as determined at the Team meeting for the discharge or transfer. When the forthcoming standard operational procedure is developed for this process, the process will be standardized across the state, to include the authorized POM/PCP process as well.

Non-Administrative Code Comment Responses:

Case Management Underfunded – The most frequent case management response received was the need to increase rates and number of units per person per year. Recommendations included increase in rates from the current approximately $48/hour to $85/hour and an increase in number of units per person per year from 36 to 60. Rationale for increased funding was to allow a reduction in caseloads, some of which are as high as 50 and to facilitate the additional duties of the new Person Centered Planning process. Case management rates and/or increase units.

Response: The Division would agree that performance data and funding requirements may require increased funding and/or the identification of additional funding streams. Several influences/data sources are being developed which will produce the hard data needed to support funding changes. An example of a hard data source will be the cost analyses provided by Case Management agencies who participated in phase one of the Meaningful Day Pilot. At this point, cost analyses are being received which reflect actual cost over the previous cost to hold an annual planning meeting. The costs associated with movement to Conflict Free Case Management can be predicted in part from those agencies who have already converted their agency to be conflict free. It is acknowledged that the number of people in the caseload of each case manager is an internal management decision fueled by funding. There is not currently an established maximum for caseloads. The national dialogue about caseload limits vary broadly because the duties and performance expectations required of a case manager dictate the number in the caseload. The Division is currently working to bring clarity to the duties of an ID case manager by the establishment of a standard operational manual. Upon its completion, targeted for Spring 2016, a plan will be developed to establish a maximum case load limit. Whether the funding changes equate to increased units per person per year or to rate changes, or both, they will be designed to most fully promote the authorized Personal Outcome Measures/Person Centered Planning (POM/PCP) processes, and the commitment to conflict free case management.

Case Management Responsibilities for the new authorized POM/PCP Process – There were three comments about the case manager‘s responsibilities for the POM/PCP process. The case manager has no authority to require the provider to follow the plan when written. Provider agencies sometimes take action unilaterally which should have been discussed in the Team. Responsibilities of the case manager to ensure the plan is implemented. “Providers & families don’t provide the information necessary to create, monitor, assess or update the Person Centered Plan, particularly in a timely manner. “

Response: The PCP is NOT written by the case manager rather it is the duty of the Team to devise the single, PCP. The role of the case manager is to ensure the meeting is facilitated so that the components of the PCP format may be completed. The case manager is regarded as the recorder of the Team’s

determinations, including who does what by when. Therefore, the single PCP is not the Case Manager's Plan. The pilots already conducted and follow-up training to be provided will gradually roll out the use of the new process. The existing Team process will be used until the new process is completely implemented. The provider's current planning process will be allowed until implementation of the new system is completed. At that time, the Plan will shift from the Provider's Plan to the Person's Plan which will be a single plan inclusive of all services for the person by all relevant providers and/or team members. The authority for the provider to implement the Person Centered Plan rests with the DMH, once the expectation is made clear in writing and via in-servicing. As always, failure to carry out planned goals/objectives or to take the action determined by the Team should be reported to the DMH regional office for action. Reluctance to adopt the changes will hopefully be mitigated through provider training, DMH oversight, and monitoring processes. The need to more fully train the participating provider in the new system has been identified as a need from the Pilot phase 1 feedback. As to the authorized POM/PCP implementation, each goal/objective/activity is assigned to a responsible person with a target date. It is the role of the case manager to monitor that the person assigned to implement the activities on the plan gives evidence that the service has been delivered. The case manager implements only those activities listed on the PCP which are assigned to the case manager. Providers and/or other team members implement the remainder of the plan. There is agreement with the comment that the case manager is not a direct service provider. The requirement of a provider to provide adequate information for the Plan and subsequent updates is not new. In the forthcoming Standard Operational Procedure for the case management narrative, a DMH created procedure is listed for use by the case management entity. This procedure does not extend to the family or the person, nor is it anticipated that a procedure will be developed which requires the family to provide requested information which the Team may find useful to plan. However, routine invitations to the family should be included in the planning process, as always, unless prohibited by the person supported.

Case Management Forms/Documentation Systems – Although not directly related to the Administrative Code, two agencies forwarded comments about the number of required forms, amount of time spent on documentation in lieu of contact with the person; lack of a consistent documentation system for case managers and recommendations for a paperless and electronic signature system.

Response: Since Medicaid monitors entirely or in part the case management services from the record/chart, written evidence of case management services will continue to be required. With the gradual implementation of the new POM/PCP planning system, it is anticipated that by the end of 2016, the use of the Case Management Plan will be approved by Medicaid for discontinuance. This discontinuance will apply only with the use of the new POM/PCP process. This discontinuance removes the duplicity of the case management goals/objectives on both the PCP and the Case Management Plan. The removal of the other assessment documents required by regulations will be limited at the point of full removal of the Case Management Plan because of the assessment contained in Section 1 of the Case Management Plan will be gone.

A required single case management documentation system will not be mandated by DMH in the near future simply because many Case Management agencies have recently invested in new data collection systems. The current ADIDIS system is in use.

The move toward paperless and electronic signature systems certainly can be an item of discussion for the case management system improvement discussions in the future.